Department of Health
Office of Emergency Medical & Trauma Prevention

AIR AMBULANCE
SERVICE / VEHICLE RELICENSURE APPLICATION

Service Name: ______________________________ / ______________________________
(Legal Name) *(Also Known As)*

Address: ______________________________ EMS Agency/License #: ________
(If known)

____

City: ____________________ State: __________ Zip: ____________

Owner/Operator: ______________________________ Phone: ____________

Physician Director: ______________________________ Phone: ____________

EMS Training Officer: ______________________________ Phone: ____________

E-Mail Address: ______________________________ FAX: ____________

NOTE: This application may NOT be used to upgrade or change your agency's type of service license. Please contact our office for the appropriate forms needed to apply for a service type other than what you currently hold.

IF YOUR RESPONSE *AREA* AND/OR RESPONSE *TIMES* HAVE CHANGED SINCE YOUR LAST APPLICATION, PLEASE ATTACH A WRITTEN EXPLANATION TO THIS APPLICATION.

WOULD YOU LIKE TO CONTINUE YOUR VERIFIED STATUS? Yes ☐ No ☐ N/A ☐

DOES YOUR SERVICE UTILIZE EMS PERSONNEL? Yes ☐ No ☐

IF UTILIZING EMS PERSONNEL, PLEASE CHECK THE LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS: BLS ☐ ILS ☐ ALS ☐

ORGANIZATION TYPE: (check the <u>one</u> that ***best*** applies to your organization)

Private For Profit	☐	Private Non-Profit	☐	Private Volunteer Association	☐
Hospital District	☐	EMS District	☐	Other (specify below)	☐

____

VEHICLES: Please provide the **<u>number</u>** of each type vehicle you are licensing (see Page 2):

Air Ambulance (Fixed Wing) ☐ Air Ambulance (Rotary Wing) ☐

RESPONSE INFO: Please provide the **<u>number</u>** for each EMS activity listed below, for your last full calendar year**:**

Primary Responses	☐	Transports Primary/Secondary	☐
Secondary Responses	☐	Interfacility Transports *Only*	☐

PERSONNEL STATUS: Are your EMS personnel primarily: (check one) Paid ☐ Volunteer ☐

DO NOT DUPLICATE

AIR AMBULANCE *SERVICE / VEHICLE*
RELICENSURE APPLICATION

EMERGENCY MEDICAL *VEHICLES*

Please provide the following information for all air ambulance vehicles to be licensed. Vehicle location is the address in which the vehicle is **physically located.** Check the ***type*** of vehicle(s), fixed or rotary wing. Check to see that each licensed vehicle has a license sticker appropriately displayed. If there is no sticker, request one below.

YOUR SERVICE NAME: ______________________________

	YEAR	MAKE AND MODEL	LICENSE PLATE OR FAA NUMBER	ACTUAL ADDRESS OF VEHICLE *(If Different From Page 1)*	AIR AMB FIXED	AIR AMB ROTARY	STICKER NEEDED (Yes or No)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Attach extra sheets as necessary, including all the required information.

NOTE: When *adding, removing*, or *changing* the location of licensed vehicles, contact the licensing office, at the address or telephone number on Page 4.

DO NOT DUPLICATE

AIR AMBULANCE *SERVICE / VEHICLE*
RELICENSURE APPLICATION

EMERGENCY MEDICAL *PERSONNEL*

List all medical personnel in your organization who are providing emergency care, aid or transportation, and check the appropriate column(s). Include personnel who are full or part-time, paid or unpaid.

PLEASE KEEP A COPY OF THIS LIST ON FILE FOR INSPECTION BY THE DEPARTMENT OF HEALTH.

SERVICE NAME: ______________________________

	NAME (LAST, FIRST, M.I.)	EMT	IV TECH	AW TECH	IV/AW TECH	ILS TECH	ILS/AW TECH	PM	OTHER (Specify)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
	PLEASE TOTAL EACH COLUMN:								

Attach additional sheets as necessary, including all the required information.

Legend:
EMT = Emergency Medical Technician
IV TECH = Intravenous Therapy
AW TECH = Airway Technician
IV/AW TECH = IV and Airway
ILS TECH = Intermediate Life Support
ILS/AW TECH = ILS & Airway
PM = Paramedic
OTHER = RN, MD, PA, Flight Nurse

DO NOT DUPLICATE

AIR AMBULANCE *SERVICE / VEHICLE*
RELICENSURE APPLICATION
GENERAL OPERATION

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the State EMS & Trauma Plan. *(Please find this information on our website at* ***www.doh.wa.gov/hsqa/emtp*** ***click on "Licensure Processes."*** *If you require hard copies of this information, please contact the Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. **Dispatch plan**

2. **Response plan**

3. **Response area**

4. **Type of transport (emergency and/or interfacility), if any**

5. **Tiered response and rendezvous, if any**

6. **Back-up plan to respond (may not apply to agencies doing interfacility transports only)**

NOTE: Other services involved in your response plan must be informed by you that they are participants and must agree to that participation. Attach extra sheets as necessary.

"I/We hereby affirm and declare that the information provided is true and correct and that:

1. *Our service operates in a manner, which is consistent with the State EMS & Trauma Plan;*
2. *Our service, and all vehicles submitted for licensure on Page 2, meet minimum requirements provided in WAC 246-976 (Air Ambulance Services);*
3. *Our service meets all FAA regulations;*
4. *A copy of our current FAA certificate and operational specifications is attached to this application;*
5. *Our Physician Director is a Washington-State licensed physician;*
6. *We maintain current liability insurance coverage."*

Person Completing Application	(Print or Type)	**Date**
Owner/Operator	(Signature & Title)	**Date**

DO NOT DUPLICATE